STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING _____ B. WING _____	03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PRESTWICK	445 S COUNTY ROAD 525 EAST AVON, IN46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00087451. This visit resulted in a partially extended survey - Immediate Jeopardy. Complaint IN00087451 - Substantiated. Federal/State deficiencies related to the allegations are cited at F272, F279 and F323. Survey date: March 11, 2011 Extended survey dates: March 12, 13 and 14, 2011 Facility number: 000231 Provider number: 155338 AIM number: 100267900 Survey team: Vanda Phelps, RN Census bed type: SNF: 38 SNF/NF: 74 Total: 112 Census payor type: Medicare: 29 Medicaid: 66 Other 17 Total: 112	F0000	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 3 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/17/11 by Suzanne Williams, RN			

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F0272 SS=D	Based on observation, record review and interviews, the facility failed to conduct comprehensive assessments following a witnessed elopement during which the resident exhibited the ability to plan and execute his plan. This impacted 1 of 3 residents reviewed for exit seeking behavior in the sample of 3. (Resident X) Findings include: During the orientation tour on 3/11/2011 at 9:45 a.m., LPN (Licensed Practical Nurse) #1 identified Resident X as having eloped twice recently. He was observed at the time ambulating rapidly through the facility with a stern facial expression. He was observed in the 600 hall, the 800 hall and the front lobby. The clinical record of Resident X was reviewed on 3/11/2011 at 3 p.m. It indicated he was admitted to this facility on 12/2/2009. His diagnoses included, but were not limited to, Parkinson's disease, dementia, depression and anxiety. It indicated Resident X had exhibited exit seeking behavior and wandering consistently since admission and wore a WanderGuard device which electronically locks the doors when the device comes close to the exit.	F0272	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident X's care plan was updated on 03/08/11 in order to address the resident's ability to plan and execute an elopement attempt. Resident X was discharged from the facility on 03/16/11. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** Patients in the facility with exit seeking and unsafe wandering behavior have been identified. New admissions with exit seeking and unsafe wandering behavior have the potential to be affected and will be identified in our IDT meetings. **What measures will be put in place or what systemic changes will be made to ensure that deficient**	03/28/2011

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	The nursing notes indicated Resident X had eloped on Saturday, 2/19/2011 at 2 p.m., by sitting near the front door and, when a visitor was leaving, pushed past him while the door was still open and got outside. Although he was wearing a WanderGuard, he was able to exit because the door was already open. The visitor had immediately reported what had happened and staff were able to catch up with Resident X the equivalent of about one-half block from the door. He fell trying to elude the staff. His last MDS (Minimum Data Set) assessment was dated 2/7/2011. It indicated his short term memory was "ok," and he was not exhibiting wandering behavior during the assessment period. It was not updated after the 2/19/2011 elopement. Resident X had been periodically evaluated by a psychologist, there was no evidence this was done again after the 2/19/2011 elopement. Nursing notes of 3/7/2011 indicated staff became aware Resident X was missing at noon. After a search of the building and grounds, 9-1-1 was called. The Administrator indicated during an		**practices do not occur?** The interdisciplinary team and unit managers received training on documentation of completing assessments, prevention and management of exit seeking and unsafe wandering behaviors. Unit Managers/Designee will audit documentation 5X weekly for 4 weeks and forward results to ADNS for further actions if needed. **How will the corrective actions(s) be monitored to ensure the deficient practice will nor recur?** Audits will continue by Unit Manager/Designee weekly thereafter. ADNS will monitor documentation for assessments weekly X 4 weeks then as determined by the QA & A committee for frequency to ensure accuracy has been achieved. Findings will be forwarded to QA & A Committee for further review and recommendations.	

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	interview on 3/11/2011 at 10:50 a.m., the police dispatcher told him the police had found a resident lying in a ditch along highway 36 and an ambulance had been called. Review of the emergency room documentation on 3/11/2011 at 1:30 p.m. indicated he had arrived there on 3/7/2011 at 14:40 (2:40 p.m.), more than 2.5 hours after the facility discovered he was missing. Although the facility had investigated the second elopement, they were unable to determine how Resident X had been able to leave the facility. Interview with the Administrator and the Director of Nursing on 3/11/2011 at 4:45 p.m. indicated it had not seemed necessary to re-assess Resident X until after the 3/7/11 elopement. This federal tag relates to complaint IN00087451. **3.1-31(c)(7)** **3.1-31(c)(12)** **3.1-31(d)(1)**			

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F0279 SS=D	Based on observation, record review and interviews, the facility failed to update the care plan in a timely manner to reflect the resident's demonstrated ability to plan and execute an elopement attempt. This impacted 1 of 3 residents reviewed for exit seeking behavior in the sample of 3. (Resident X) Findings include: LPN (Licensed Practical Nurse) #1 indicated, during the orientation tour 3/11/2011 at 9:45 a.m., Resident X had wandering and exit seeking behaviors, and had recently eloped twice. He was observed at the time ambulating rapidly throughout the facility with a stern facial expression. He was observed in the 600 hall, the 800 hall and the front lobby. The clinical record of Resident X was reviewed on 3/11/2011 at 3 p.m. It indicated he was admitted to this facility on 12/2/2009. His diagnoses included, but were not limited to, Parkinson's disease, dementia, depression and anxiety. It indicated Resident X had exhibited exit seeking behavior and wandering consistently since admission and wore a WanderGuard device which electronically locks exit doors when the device comes close to that exit.	F0279	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident X's care plan was updated on 3-8-11 in order to address the resident's demonstrated ability to plan and execute an elopement attempt. Resident X was discharged from the facility on 03/16/11. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** Residents that have the potential to be affected have had their plans of care reviewed and updated as appropriate. New residents will be identified upon admission for their exit seeking behavior and unsafe wandering behaviors with care plans put in place as required. **What measures will be put in place or what systemic changes will be made to ensure that deficient practices do not occur?** The interdisciplinary	03/28/2011

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	The nursing notes indicated Resident X had eloped on Saturday, 2/19/2011 at 2 p.m., by sitting near the front door and, when a visitor was leaving, pushed past him while the door was still open and got outside. Although he was wearing a WanderGuard, he was able to exit because the door was already open. The visitor had immediately reported what had happened and staff were able to catch up with Resident X the equivalent of about one-half block from the door. He fell trying to elude the staff. Clinical record review included the care plan. There was an entry addressing elopement risk initiated on 6/21/2010, but it was not updated after the 2/19/2011 elopement. The interventions remained as: "check wanderguard placement and function q (every) shift " (initiated 6/21/2010) "ensure that (wife's name) signs resident out and makes staff aware when leaving and escort back into the building" (initiated 9/2/2010) "calmly redirect to an appropriate area, activities, meals and reassure" (initiated 9/2/2010) "encourage socialization with others and provide recreational programming,		team and nurse managers have been re-educated on the proper procedures for prevention and management of exit seeking behavior and unsafe wandering behaviors. Social Service and License Nursing staff have re-educated on exit seeking and unsafe wandering behavior and care plans and assessment. Residents identified as having exit seeking behaviors and unsafe wandering behaviors have had their medical record reviewed to ensure the appropriate tracking tools and care plans are in place with the appropriate interventions addressed. **How will the corrective actions(s) be monitored to ensure the deficient practice will nor recur?** Resident's exit seeking and unsafe wandering behavior will be monitored 5X a week for 4 weeks by Social Service or designee to verify all residents with exit seeking or unsafe wandering behaviors have been appropriately addressed. Residents with any new areas of concern will be addressed and care plans will be implemented at that time. The Administrator/Designee will audit social service documentation through 2 chart audits per week for 4 weeks and then as determined by the QA & A committee, of current residents with exit seeking behaviors to ensure the care plans are	

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	woodworking, read magazine" (initiated 9/2/2010) Nursing notes on Monday, 3/7/2011, indicated facility staff became aware Resident X was missing about 12 noon. He had last been seen at approximately 11:55 a.m. A systematic search of the building and grounds failed to locate Resident X so 9-1-1 was called. The resident was found by police 1.5 miles from the facility lying in a ditch along State Road 36. Review of Emergency Room documentation on 3/11/2011 at 1:30 p.m. indicated Resident X arrived there at 2:40 p.m., i.e. 2.5 hours after facility staff noticed he was missing. Two new interventions were added to the care plan entry addressing elopement risk on 3/8/11: " place picture in Center Watch Book and on bulletin board" (initiated 3/8/2011) "allow to vent feelings and/or frustration prn and assist with calling wife, kids, or brother to assist with calming down" (initiated 3/8/2011) During interview 3/11/2011 at 4:45 p.m., neither the Administrator nor the Director of Nursing offered an explanation for failure to update the care plan after the 2/19/2011 elopement.		appropriate. The results of the audits will be submitted to QA & A Committee for further review and recommendations.	

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	This federal tag relates to complaint IN00087451. 3.1-35(b)(1)			

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F0323 SS=J	Based on observaton , record review and interview, the ffacility ffailed to monitor and provide supervision to ensure the saffety off a resident with a history off exitng the ffacility resultng in Immediate Jeopardy because off the risk off serious harm,injury, or death to 1 off 3residents reviewed ffor exit seeking behaviors in the sample off3. (Resident X) The Immediate Jeopardy began on 2/19/2011 when a resident was returned to the ffacility affer an elopement and without the implementaton off a plan to prevent ffurther elopements The Administrator and Director off Nursing were notffed off the immediate jeopardy at 4:45 p.m. on 3/11/2011. The immediate jeopardy was removed on 3/07/2011 when, based on record review and interview, the resident was placed on contnuous 1:1 monitoring, but the noncompliance remained at the lower scope and severity level off isolated with no actual harm with potental ffor more than minimal harm that is not immediate jeopardy because the ffacility ffailed to ffully implement a plan to prevent the resident ffrom exitng the ffacility in the ffuture Findings include: Resident X was identified by LPN (Licensed Practical Nurse) #1, during the orientation tour 3/11/2011 at 9:45 a.m., as having exit seeking and wandering behaviors. In addition, she reported he had eloped twice. One witnessed and the other unwitnessed. He was observed at the	F0323	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident X was returned to the facility and immediately placed on 1: 1 supervision. Resident X was discharged from the facility on 03/16/11 **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** Residents will be identified on admission for the risk of exit seeking. On a monthly basis resident who are currently identified as exit seekers or who have had a significant change will be reviewed for ongoing need for precautions. Residents were assessed for elopement risk with care plan updates as needed. Residents identified as a risk for elopement have had their pictures placed in the facility watch book located at the receptionist desk, both nursing stations as well as the employee break room	03/28/2011

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	time ambulating rapidly through the facility with a stern facial expression. He was observed in the 600 hall, the 800 hall and the front lobby. Resident X's clinical record was reviewed on 3/11/2011 at 3 p.m. It indicated he was admitted to this facility on 12/2/2009. His diagnoses included, but were not limited to, Parkinson's disease, dementia, depression and anxiety. It indicated Resident X had exhibited exit seeking behavior and wandering consistently since admission and that he periodically expressed delusions that his wife was leaving him and he needed to be home. He also experienced dreams of a similar nature which he found difficult to separate from reality. At these times, his anxiety levels rose and he became agitated and intensely exit seeking. He was wearing a WanderGuard device which electronically locks the doors when the device comes close to the exit. The nursing notes indicated on Saturday, 2/19/2011, Resident X stayed in the front lounge near the main exit. When a visitor exited the main door around 2 p.m., Resident X "bolted" from a chair in the lounge where he'd been sitting and exited the door while it was still open, pushing past the visitor on his way to the outside. The visitor alerted staff who then found the resident in the yard of adjacent condominiums, equivalent to a half block from the door. He fell as he attempted to elude the staff and was brought back inside. A documented and signed interview of LPN #2 on 2/19/2011 indicated Resident X was" upset about his wife." In response to the 2/19/2011 elopement, the facility initiated 1:1 staff monitoring of Resident X. His wife took him on a leave of absence from the facility and he appeared calm upon his return,		identifying them as elopement risks. **What measures will be put in place or what systemic changes will be made to ensure that deficient practices do not occur?** All deliveries other than regular mail or small packages are now made to the rear service entrance, away from all resident common areas. Coded entry locks have been added to the entrances leading to the service hall. A new camera was installed in the front lobby with a corresponding monitor installed for viewing from the North nurses' station. Magnetic locks, keypads and Wander Gard Systems were installed at the exits from the North and South dining rooms. Staff have been re-educated regarding exit seeking behavior and unsafe wandering. This education has been added to the general facility orientation agenda and new staff will receive the education before completion of their orientation **How will the corrective actions(s) be monitored to ensure the deficient practice will nor recur?** The facility will continue with missing resident drills once per shift per month with the Safety Chair person or designee reviewing results with the monthly QA & A. Daily audits of door/alarm functionality by the Maintenance director or designee and reviewed by the monthly QA & A committee. Wander guard	

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	so the 1:1 monitoring was discontinued. The facility checked all WanderGuard doors and bracelets and window stops and inserviced staff on facility elopement procedures. However, the fact that resident X had demonstrated he could plan an elopement and carry it out was not addressed. Review of his care plan indicated there was an entry addressing elopement risk initiated on 6/21/2010, but it was not updated after the 2/19/2011 elopement. The interventions remained as: "check wanderguard placement and function q (every) shift " (initiated 6/21/2010) "ensure that (wife's name) signs resident out and makes staff aware when leaving and escort back into the building" (initiated 9/2/2010) "encourage socialization with others and provide recreational programming, woodworking, read magazine" (initiated 9/2/2010) Nursing notes on Monday, 3/7/2011 indicated facility staff became aware Resident X was missing at about 12 noon. He had last been seen at approximately 11:55 a.m. A "code green" was announced, which the Administrator indicated during interview 3/11/2011 at 10:50 a.m., was the facility's protocol for announcing to staff a resident was missing, at which time staff systematically searched the building and grounds. When Resident X was not located, the Administrator called 9-1-1. He indicated that while talking with the dispatcher, she told him the police had located the resident. Passers-by had spotted the resident lying in a ditch at the intersection of U.S. highway 36 and County Road 400 and notified the police. The Administrator indicated he'd sent the Maintenance Supervisor to check on the resident, but EMTs already had the resident in the ambulance and told him the resident was being sent to the emergency room.		bracelet are checked every shift with functionality checked daily. Unit Manages will complete daily audit 5X weekly for 4 weeks and any areas of concern will be addressed immediately and then as directed by the QA & A committee. The Social Service Director/Designee completes a weekly audit of the facility watch books located at the receptionist desk, both nursing stations as well as the employee break room to assure they remain current and reviews this with the monthly QA & A committee.	

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Weather information obtained from the "History for KIND, Indiana" website 3/13/11 at 9 p.m. indicated on 3/7/2011 in the Indianapolis area, the temperature at 12:30 p.m. was 35.6 degrees Fahrenheit with a wind speed of 9.2 miles per hour. At 2:54 p.m. the temperature was 39.9 degrees with a wind speed of 9.2 miles per hour. The Administrator indicated during interview 3/11/2011 at 10:50 a.m., Resident X was dressed in a long sleeved T-shirt with another shirt pulled over that, slacks and moccasins. He was not wearing a jacket, coat, sweater, etc.

Review of the emergency room documentation for Resident X was done on 3/11/2011 at 1:30 p.m. It indicated the resident was received in the emergency room at 14:40 (2:40 p.m.) on 3/7/2011, which was 2.5 hours after the resident was noted missing from the facility. He had fallen in a ditch along highway 36. He was discharged from the emergency room at 18:42 (6:42 p.m.) with diagnoses of "back pain and injury, contusions, facial & scalp contusions, neck injuries and urinary tract infection."

The clinical record indicated Resident X was again placed on 1:1 monitoring which was still in effect on 3/11/11. The elopement risk care plan had been updated 3/11/2011. The new interventions were: "place picture in Center Watch Book and on bulletin board, allow to vent feelings and/or frustration prn (as needed) and assist with calling wife, kids, or brother to assist with calming."

There was no evidence a psychological evaluation had been sought for Resident X since this elopement.

The Administrator made an entry in the Social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING _____ B. WING _____	03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PRESTWICK	445 S COUNTY ROAD 525 EAST AVON, IN46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Service progress notes dated 3/11/2011. In this entry he documented a conversation with Resident X's family and indicated other placement was being sought for Resident X for his safety. "...Explained we strongly recommend a secured unit for him...Family wants to consider other options. Explained that we would like to move (Resident's name) asap (as soon as possible) but within 30 days if possible. Family expressed desire for continued basis w (with) (resident's name). I cautioned that his desire to elope is erratic and unpredictable and that he should be within eyesight at all times...Family agreed to review all discharge options and cooperate." During interview 3/11/2011 at 10:50 a.m., the Administrator indicated they had not been able to determine how Resident X eloped on 3/7/11. He indicated all staff had been interviewed and Resident X wasn't telling. An immediate jeopardy was identified on 3/11/2011 at 4:45 p.m. The immediate jeopardy began on 2/19/2011 when Resident X first eloped from the facility. The Administrator and the Director of Nursing were notified of the immediate jeopardy related to lack of supervision to prevent an elopement on 3/11/2011 at 4:45 p.m. The immediate jeopardy was removed on 3/7/2011 when records and interviews conffrmed that the resident was on contnuous 1:1 monitoring since return to the ffacility The ffacility' s noncompliance remained at the level off no actual harm with a potental ffor more than minimal harm that is not immediate jeopardy because the ffacility needed to ffully implement its plan to make the site ffor supply deliveries more			

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	secure; to install a key pad lock; to update its Center Watch Book; to install surveillance cameras on the main entrance area; and to inservice all staff. This federal tag relates to complaint IN00087451. 3.1-45(a)(2)			